carolina complete health

Immunomodulators Temporary PA Request Form

Non-Radiographic Axial Spondyloarthritis (Cimzia, Cosentyx and Taltz)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI#: _____

7. Requester Contact Information - Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Med requested: _____9a. Strength____9b. Quantity per 30 days___9c. Length of Therapy____

10. Does the member have a diagnosis of Non-Radiographic Axial Spondyloarthritis? **YES___ NO____**

11. Is the member on any other injectable immunomodulator? **YES**___ **NO**___

12. Has the member been screened for latent tuberculosis infection? **YES**___ **NO**___

13. Has the member been tested with Hep B SAG and Core Ab? **YES**___ **NO**____
Date of lab and result_____
_____
_____

14. Has the member failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID)? **YES**___ **NO**___
If no, please list the contraindications that the member has to trial of NSAIDS:
_____
_____

15. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use the preferred.
_____
_____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.